Ethnic variations in compulsory detention: a Systematic Review and Meta-Analysis of the international data.

Phoebe Barnett¹, Euan Mackay¹, Hannah Matthews¹, Rebecca Gate², Helen Greenwood², Kevin Ariyo¹,², Kamaldeep Bhui⁴, Kristoffer Halvorsrud⁴, Stephen Pilling¹,²,³ and Shubulade Smith²,⁵,⁶

Correspondence: Phoebe Barnett, Centre for Outcomes Research and Effectiveness, Department of Clinical Educational and Health Psychology, University College London, UK. Email: phoebe.barnett@ucl.ac.uk

¹ Centre for Outcomes Research and Effectiveness, Department of Clinical Educational and Health Psychology, University College London, 1-19 Torrington Place, London, WC1E 7HB

² National Collaborating Centre for Mental Health, Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

³ Camden & Islington NHS Foundation Trust, 4 St Pancras Way, London, NW1 0PE

⁴ Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, Charterhouse Square, London, EC1M 6BQ

⁵ Kings College London, Department of Forensic and Neurodevelopmental Science, Institute of Psychiatry, Psychology and Neuroscience, Decrespigny Park, London SE5 8AF

⁶ South London and Maudsley NHS Foundation Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX

Running Title: Ethnic variations in compulsory detention: a Systematic Review and Meta-Analysis of the international data.

Word count: 3219

Role of funding source: SP was supported by funding from the UCLH National Institute for Health (NIHR) Biomedical Research Centre. SS was supported by the NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London. No funding bodies had any role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.
Ethnic variations in compulsory detention: a Systematic Review and Meta-Analysis of the international data.

Phoebe Barnett, Euan Mackay, Hannah Matthews, Rebecca Gate, Helen Greenwood, Kevin Ariyo, Kamaldeep Bhui, Kristoffer Halvorsrud, Stephen Pilling and Shubulade Smith

Abstract

Background: Evidence suggests Black, Asian and Minority Ethnic (BAME) groups are at increased risk of involuntary psychiatric care. However, there is no published meta-analysis which brings together both international and UK literature and allows for comparison of the two. This study examines compulsory detention in BAME and migrant groups in the UK and internationally.

Methods: A systematic review and meta-analysis of quantitative studies comparing involuntary admission, readmission and length of stay in BAME or migrant groups, compared to majority, or native groups was conducted. Explanations offered for the differences were assessed for the strength of evidence supporting them.

Findings: Seventy studies were included. Black Caribbean patients had the highest odds ratio of detention (2.53, CI:2.03-3.16). Black African patients had significantly increased odds (2.27, CI:1.62-3.19), as did, to a lesser extent, South Asian patients (1.33, CI:1.07-1.65). Black Caribbean patients had significantly increased odds of readmission (2.30, CI:1.22-4.34). Migrant groups had increased odds of detention compared to native groups (1.54, CI:1.22-1.95). Evidenced explanations included increased perceived risk of violence and police contact with BAME groups.

Interpretation: BAME and migrant groups are disproportionately at risk of psychiatric detention, though there is variation across ethnic groups. Attempts to explain elevated rates of detention in ethnic groups should avoid amalgamation and instead conduct culturally specific, hypothesis driven studies examining the numerous contributors to varying rates of detention.

Funding: SP was supported by funding from the UCLH National Institute for Health (NIHR) Biomedical Research Centre. SS was supported by the NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London.
**Research in Context**

**Evidence before this study**
A large body of evidence suggests that Black, Asian and Minority Ethnic (BAME) groups are at a higher risk of compulsory detention under the Mental Health Act in England and Wales. However, there is marked variation in the composition of ethnic groups, definitions of ethnic groups, sample sizes and reported magnitude of the effect sizes. The literature has typically focused on small numbers of countries (e.g. the U.K) and often neglected migrant populations. There is no current meta-analysis of both international and UK literature. MEDLINE (1946-November 2017), and PsycINFO (1806-November 2017) databases were searched. Search terms were “minority groups” or “ethnic groups” or “BME” or “BAME” or “immigrants” or “refugees” and “Mental Health Act” or “commitment” or “admission” and “psychosis” or “schizophrenia” or “psychotic disorders”.

**Added value of this study**
This is the first systematic review and meta-analysis to review both international and UK based studies of compulsory detention, and the first to consider compulsary detention in migrant populations. This review benefits from separate consideration of different ethnic groups where possible, avoiding grouping of culturally diverse populations. UK based and international research demonstrated significantly increased rate of compulsory detention in several different ethnic minority populations and migrant populations, though UK research demonstrated a more pronounced rate.

**Implications of all the available evidence**
Our findings support the view that the rate of compulsory detention and readmission in all BAME populations is significantly increased compared to majority groups, as is that of migrant compared to native populations. Rates vary across different BAME groups, with highest rate seen in Black Caribbean populations, and less marked, but still significantly increased rates in south Asian populations. Future research should aim to establish the causes of ethnic disparities in involuntary care. Future research should avoid cultural stereotypes and assumptions, and amalgamation of ethnic groups should be discouraged to better inform policy and practice.

**Introduction**
Ethnic minorities are subject to disproportionate risk for involuntary psychiatric detention. 1-3 Research suggests patients from Black, Asian and Minority Ethnic (BAME) groups have more compulsory admissions, 4, 5 longer inpatient stays, 6 and more readmissions. 7 However, research is conflicted, with other studies reporting no, or weak associations between BAME populations and increased detention. 8, 9 Furthermore, the risk of involuntary psychiatric detention is not consistently higher in all or specific ethnic groups, 8-10 potentially undermining actions to reduce inequalities and inform policy. While evidence from the UK suggests higher rates of detention under the Mental Health Act (MHA) for Black populations, 11, 12 less is known about South Asian populations (Bangladeshi, Indian, Pakistani, Sri Lankan, Nepali), 9, 10, 13, 14 and migrant populations. 15 A wide range of explanations have been suggested for the observed disparities, such as higher rates of schizophrenia in some minority ethnic 5, 11 and migrant 16, 17 populations, a lack of patient awareness of mental health issues, 10, 18 more frequent adverse experiences with mental health services, 19 experience of racism or healthcare provider discrimination 20, 21 and differential use of psychiatric services. 22, 23 However, very few explanations provide adequate supporting evidence. 10 A meta-analysis conducted in 2013 3 highlighted the importance of ethnic specificity in study design, considering Black Caribbean patients separately in addition to ‘Black’ patients more generally. However, there has otherwise been little evidence to systematically update and pool the current knowledge of the overrepresentation of BAME populations in the use of the MHA in England since its revision, and no systematic review or meta-analysis which takes an international perspective. This review aims to update existing systematic reviews and meta-analyses 1, 3, 10 on the rates of detention for specific BAME populations, from an international perspective, and outline explanations for any disparity. Novel considerations of migrant populations are also reported.

**Method**
This review follows the PRISMA guidelines \(^2\) and has been prospectively registered on PROSPERO (CRD42017078137). There were two main changes to our methods following protocol registration:

1. We expanded our inclusion criteria to encompass international literature in addition to that from England and Wales. This was to provide an international context to further our understanding and also to include migrant populations, who are focused on more frequently in the international literature.
2. We excluded non-English papers for practical reasons (K=4).

In addition, we conducted post-hoc metaregression analyses to a) explore potential relationships between predictor variables and ethnicity and b) account for heterogeneity.

**Inclusion Criteria**

Population: Studies of samples where two or more ethnic groups of any age were compared.

Intervention: No interventions were compared, instead risk of compulsory inpatient psychiatric care in minority, compared to majority ethnic groups was examined.

Outcomes: Compulsory inpatient admission to hospital, compulsory inpatient readmission to hospital, inpatient length of stay.

Study Designs: Quantitative studies.

**Search Strategy**

The search strategy was developed in consultation with an information scientist with experience in mental health, using a combination of keyword and subject headings. MEDLINE (January 1\(^{st}\) 1946-27\(^{th}\) November 2017), PsycINFO (January 1\(^{st}\) 1806-13\(^{th}\) November 2017), EMBASE (1974-20\(^{th}\) November 2017), CENTRAL (all years-27\(^{th}\) November 2017) and CINAHL (January 1\(^{st}\) 1981-30\(^{th}\) November 2017) databases were searched for English language papers. While the search was not confined to countries where black and other non-white ethnicities are minorities, all papers meeting inclusion criteria used either “white” or the dominant national group as their comparison group. Full search strategies are available in the Appendix pages 1-18. Two reviewers (EM, KA) independently screened all titles and abstracts identified and excluded studies that did not meet inclusion criteria. Full-text articles were subsequently reviewed in duplicate and in cases of disagreement consensus was achieved through the referral of a third senior reviewer (HM). An update search was conducted in December 2018 to identify any additional papers published between November 2017 and December 3\(^{rd}\) 2018. The search and screening process is depicted in Figure 1. The search strategy was also supplemented with a backward reference search of included studies and a forward citation search using Scopus. References for all included studies are available in the Appendix pages 41-43.

**FIGURE 1.**

**Data Extraction**

Four independent reviewers (PB, EM, HG and KA) extracted the data and all extraction was reviewed for accuracy. An electronic excel-based form was used to record data extraction. The data extracted includes: study design, sample size, population, country, diagnosis, age, sex, ethnicity, marital status, living status, education, occupation, the legal system or act, and our primary outcome measures and their associated statistical data. Included studies were restricted to papers published since 1983, to reflect the publication of the MA 1983 in England and Wales.

**Quality Assessments**

Four reviewers (PB, EM, HG and KA) quality assessed the included studies. Firstly, the Kmet 14-item quality assessment checklist was applied to each study \(^5\). Each study was assessed against the 14 items using a 3-point scale with a score of 2 representing fully met, 1 partially met, and 0 did not meet the criterion. A total score was calculated by summing the score achieved for each item. If a criterion was not applicable, it was excluded from the score calculation, and the maximum total score that could be achieved. A summary score (total sum/total possible sum) was then calculated, representing the methodological quality of each study. These scores were calculated as a linear score from 0 to 100 and divided into 3 categories representing low (49 or less), moderate (50-74), or high (75 or more) quality studies. Secondly, the quality of each study in terms of ethnic specificity
was also assessed using an adaption of Raine’s review of gender differences within healthcare, developed by Bhui et al and used in previous similar reviews. Quality rating scores ranged from 0 to 14 and were categorised as follows: 0 – 3 = “Low”, 4 – 7 = “Medium”, 8 - 14 = “High”. For both scales quality assessment was discussed until consensus was obtained and disagreements were resolved through consultation with two senior reviewers (SP, HM).

Explanations and evidence base

Following Singh et al., explanations for differences in psychiatric detention of BAME groups were extracted from included studies. These were summarised and support from primary evidence (data from the paper itself) recorded. Unsupported explanations were those untested in the study design of the paper itself. Explanations were classified into 5 domains, adapted from Singh et al: patient-related, illness-related, service-related, culture-related, and service-patient interface. If studies were previously summarised by Singh et al., those explanations were retained. We only reported explanations where primary evidence for an association was identified.

Data Analysis

We calculated overall summary estimates (Odds ratio, OR) and 95% Confidence Intervals (CIs) with a random-effects model using Comprehensive Meta-Analysis software (CMA version V3) and the metafor package in R. P-values below 0.05 were considered significant. ORs were used as most papers either provided number of events and sample sizes to calculate ORs, or gave statistics in OR format when raw data was not provided. Papers varied in their specificity of classification of ethnic groups. Unlike previous studies, we attempted to avoid aggregate comparisons. Where possible, studies were organised in sub-groups of “Black Caribbean”, “Black African”, “South Asian”, and “East Asian”. Studies solely reporting for ‘Black’ or ‘Black other’ groups were classified as “Black, unspecified”. A further non-specific classification of “BAME unspecified” was constructed to contain studies reporting a mixture of minority ethnicities, e.g. “non-white British”. We also conducted an analysis on studies comparing migrant groups (those born outside the host country) to host populations. Only unadjusted data was included in the analysis.

Four metaregressions were conducted post-hoc to explore possible causes of heterogeneity, and to consider differences between UK and international literature. They examined possible predictors of the effect of ethnicity on compulsory admission and included: mean age, proportion of females, publication year and national context (England and Wales or internationally). Sensitivity analyses were also conducted, including only studies rated as high quality or higher ethnic specificity on the primary outcome compulsory admission.

The heterogeneity between studies was calculated using the I² statistic. A value of 0% represents no observed heterogeneity and 25%, 50%, or 75% tentatively signifies low, moderate, or high heterogeneity between studies, respectively. The degree of publication bias was assessed through visual examination of funnel plots.

Results

The search returned 9511 studies from which 297 potentially relevant full-text articles were identified. Of these, 66 studies met inclusion criteria. An additional 4 studies were also included from reference and citation searches. An update search conducted December 2018 yielded no additional studies meeting inclusion criteria. A substantial number of participants were included in the studies of this review (N=1,952,322). Study characteristics are summarised in Table 1. The 70 studies reported compulsory admission (K=62), compulsory readmission (K=11) and inpatient bed days (K=2). Two studies reported rate ratios, and one a risk ratio, which could not be pooled and included in our meta-analysis. Four studies reported adjusted data only so were also excluded from the analysis. Most studies reported routine data from specific hospitals or districts, although some compared population rates of admission. Studies were from high-income countries, predominantly from the U.K (K=49). Other countries represented were Canada (K=2), Italy (K=3), Ireland (K=2), The Netherlands (K=3), USA (K=5), Norway (K=1), Switzerland (K=2), Denmark (K=1), Spain (K=1) and New Zealand (K=1). High levels of variability in study quality were demonstrated as were scores awarded on the ethnicity checklist, with scores ranging from two to 12. The main areas of bias centred on a lack of consideration for confounding variables. Funnel plots were examined to explore publication bias and studies were evenly distributed around the standard error (Appendix p19-22)- which suggests that publication bias did not significantly impact on our results. However, a high level of heterogeneity was observed for all outcomes (Table 2).
TABLE 1
Results for comparisons of all BAME groups with majority groups are presented in Table 2. Black ethnic groups were significantly more likely to be compulsorily admitted than White ethnic groups (Black unspecified OR=2.00, CI:1.28-3.11, Black Caribbean OR=2.53, CI:2.03-3.16, Black African OR=2.27, CI:1.62-3.19). Black Caribbean patients were also significantly more likely to be readmitted to hospital (OR=2.30, CI:1.22-4.34). There was no significant effect on inpatient bed days (OR=0.88, CI:0.18-4.19), although this comparison only included two studies. People from Asian ethnic groups were significantly more likely to be compulsorily admitted than people from white ethnic groups (South Asian OR=1.33, 1.07-1.65, East Asian OR=2.17, CI:1.47-3.22). Only two studies reported readmission in South Asian patients, these were non-significant. The ‘other minority ethnicities’ group was also significantly more likely to be compulsorily admitted than majority groups (OR=1.66, CI:1.29-2.14), as were migrant populations (OR=1.54, CI:1.22-1.95). Forest plots for analyses are provided in the Appendix p23-28.

TABLE 2
Results of metaregressions are shown in Table 3. Study location was a significant predictor of compulsory admission in Black unspecified groups, such that UK studies reported significantly higher odds of compulsory admission in Black ethnic groups than international studies. Proportion of females in the sample was also a significant predictor of compulsory admission in Black unspecified, Black Caribbean, and South Asian groups. This remained significant when adjusting for age in Black unspecified, and Black Caribbean groups, but was no longer significant in South Asian groups. Publication date was only a significant predictor of compulsory admission in Black Caribbean groups, and mean age was not a significant predictor. Scatter plots are provided in the Appendix p29-33.

TABLE 3
Secondary analyses were conducted on compulsory admission data, to examine the effect of study quality on results. Results are reported in Table 4. When including only studies scoring highly on the Ethnicity checklist, estimates remained significant. When including only studies rated highly with the Kmet quality assessment scale, results remained significant in all Black ethnic groups, but became non-significant in South Asian groups. Few studies scored highly on both quality assessment scales (K=6), making these analyses difficult to draw conclusions from.

TABLE 4
Explanations
Explanations for disparities in psychiatric detentions were extracted from all papers included in the review (Appendix p34-40). Of 70 studies, 12 offered no explanation of differences in psychiatric detention of BAME groups (Appendix p34), 21 studies solely offered explanations unsupported by primary evidence (Appendix p35-37), and 37 studies offered at least one explanation supported by primary evidence (Appendix p38-40). Twenty-four classifications of explanations emerged over five domains (Appendix p34), of which ten were unsupported by any of the included literature, seven had a mix of supporting and contradicting primary evidence, and seven were supported by primary evidence. Explanations most commonly evidenced include: increased rates of psychosis; increased perceived risk of violence; increased police contact; absence of or mistrust of GP; and ethnic disadvantage. In contrast, unsupported explanations for disparities in detention frequently mentioned were: higher rates of comorbid drug use in BAME; language barriers; poorer detection of mental illness; and greater stigma.

Discussion
This review updates research on the use of involuntary psychiatric detention in ethnic minority communities. Black ethnic groups (Black Caribbean, Black African, Black Unspecified) were 2-2.5 times more likely to be involuntarily admitted compared to White populations. Black Caribbean individuals also demonstrated an increased risk of readmission. South Asian groups displayed significantly increased risk of involuntary admission, as did East Asian patients, though interpretation is limited by small study numbers. Observed associations for compulsory admission remained significant when restricted to studies we assessed as being of high ethnic specificity. Following restriction of analysis to studies with a high methodological quality rating,
only the South Asian comparison became nonsignificant. This reduction in point estimate could suggest that the less methodologically sound studies drive the effect reported in South Asian populations of higher risk for detention. In contrast, continued significance when only examining studies with high ethnic specificity (regardless of other methodological aspects) contradicts this result. Most confidence would be drawn from studies of both high methodological quality and clarity and consistency of ethnic classification, but disappointingly few studies demonstrated this (7 studies in total).

BAME Unspecified and migrant groups, both ethnically and culturally heterogeneous, also showed increased risk of involuntary admission. Together, this suggests that while effect estimates are lower than some previous literature, all minority populations internationally, including migrants, were subject to increased risks of detention.

Publication date predicted the association of Black Caribbean ethnicity and involuntary care, with recent studies reporting lower effect estimates. This may reflect more rigorous study designs in recent literature. UK-based studies also showed higher risk for Black Unspecified groups compared to international literature. The high heterogeneity seen in all groups despite our attempt to provide specific ethnic classifications could also reflect this variation in the UK and internationally. However, this effect is difficult to disentangle, as international data was limited in number and typically lacked the specificity of ethnic classification more common to British studies, preventing further post-hoc examination across all groups. The proportion of females in the sample strengthened associations in Black Caribbean, Black Unspecified and South Asian groups. While significant, whole sample proportions cannot adequately describe intersectional experiences of race and sex and require future, robust, inquiry. Data on readmission and length of stay was limited, and socioeconomic and clinical moderators by ethnic group and involuntary status were seldom reported, preventing meaningful investigation.

Of 70 papers, 47% offered no explanation of variations in risk for detention among minority groups, or solely offered explanations without support from primary evidence. Untested explanations perpetuated in the literature largely dealt with lifestyle, cultural health beliefs, clinical characteristics, and demographic bound assumptions of minority ethnic groups (e.g. higher rates of drug use, greater community stigma of mental illness). Such untested hypotheses are of limited utility, and problematic when applied to aggregated and non-specific ethnic groupings, which often contain populations of varying lifestyles, health beliefs, culture, religion and other demographic variables. Using assumptions in combined groups, which fails to consider intersectionality in perpetuation of risk, precludes further inquiry into the range of risks these groups are subject to. Explanations with supporting evidence likewise require close examination, such as increased rates of psychoses in minority groups. Psychosis alone is not a criteria for detention under the MHA, therefore prevalence of psychoses in BAME communities is insufficient to explain ethnic inequalities in detention. The excess of detentions also applies to readmissions, not just those presenting with a first episode, but rather a function of care experiences in those with established psychoses. Differences leading to mental illness trajectories that result in detention, such as perceived risk of violence warrant further investigation.

There are a number of limitations in the current review. Principal among them is that included studies examined psychiatric hospitalisation only. This provides a good base for examining inequalities in psychiatric care, but ethnic differences in other psychiatric contexts should also be examined through robust research. Additionally, the limited data on other aspects of care provided in most studies and the pooling of data in a meta-analysis cannot provide the necessary detail on the nature of differences in admissions, both formal and informal: Coercive non-formal admissions can also happen, and perceived coercion can significantly impact experience of care. Furthermore, both civil and forensic commitment were combined in the analysis. This allowed a broader inclusion of literature but it should be noted that significant differences between the two forms of compulsory hospitalisation could have been missed. On a similar note, significant differences in legal systems of the different countries included in this review should not be ignored. However we believe that providing international data on ethnic disparity gives a clearer picture of the shortcomings of present research in tackling a global problem. On this note, exclusion of non-English papers (K=4) could have led to omission of important international data.

This review is, to our knowledge, the most comprehensive to date on ethnicity and involuntary psychiatric hospitalisation; integrating international comparisons and psychiatric detention of migrants. However, a substantial portion of the literature presented lacked the methodological quality to allow us to draw mechanistic and causal inferences from it. The included studies provide little information on socioeconomical, cultural or structural determinants of detention and integrating data on detention with such factors is an important area for
Retention of untested explanations in the studies covered by this review can entrench narratives of racial determinism and contribute little to a fuller understanding of the range of inequalities faced by minority ethnic groups who come into contact with psychiatric services. Research should prioritise longitudinal study designs which can investigate clinical, socioeconomic and demographic contributions, avoiding simple techniques to analyse complicated problems. Ethnicity is a complex construct which stands for an interaction of multiple variables. Research should also integrate qualitative assessment of service provider biases, group level stigma, or patient mistrust of health service to gain a thorough understanding of individual patient experience. Decision making processes in psychiatric detention, which exclude patient and family input of risk management, must likewise be examined as their interaction with situational factors such as available alternative treatment and under-resourced services may reflect area deprivation experienced by BAME communities.

Conclusions

This meta-analysis demonstrates that all minority populations studied were subject to an increased risk of involuntary psychiatric detention. We are no closer to understanding or effectively addressing these ethnic inequalities in psychiatric care. Only research committed to well-designed longitudinal studies and multisectoral, intersectional approaches, will be able to untangle the causes of this health care inequality.

Lived Experience Commentary
Steve Gilbert

Reading the research presented in this review makes it clear that while research has been done with the best of intentions, and hopes for change, it hasn’t been adequately rooted in the people it is trying to help. Attempts to highlight the injustices have backfired, and given ammunition to those people who are not willing to stop and think—we have left our research too open to interpretation. We need to be asking different questions when considering study design—that is, we should seek not just to say what the state of play is, but also why the state of play is how it is. Another key question is who is doing the research? Research can and should be done by a range of people, who have followed different trajectories. Relevant to ethnicity and compulsory detention, experience of the criminal justice system, ethnic discrimination or low income households will positively contribute to conclusions drawn. Furthermore, the methodology of research to date has felt distant—it does not reflect “real experience”. Data is good, and useful to contribute to a full understanding, but have we become entrenched in the data? It is wrong to assume that if data says something is true that it must be true.

This paper is based on independent research and is written in collaboration with the National Institute for Health Research Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm’s length bodies, and other Government Departments. Steve Gilbert is a member of the Mental Health Act review working group, and provided a statement to accompany this report.

Authors contributions: SS was responsible for the original proposal and SS, RG and HM were responsible for drafting the original protocol. PB, HG, KA and EM were responsible for screening papers, extracting data and independently screening and extracting. HM acted as a senior reviewer in case of disagreement. HM and PB wrote the statistical analysis plan and performed the statistical analysis. PB wrote the initial draft of the manuscript. SP, SS, KB and KH provided content expertise, methodological guidance and interpreted the findings in the context of the wider literature. All authors contributed to consecutive drafts and approved the final manuscript. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting criteria have been omitted.

Conflict of interest statements: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf. All authors declare no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; and no other relationships or activities that could appear to have influenced the submitted work.
References Cited in Text


38. Livingston JD. Experiences of stigma and compulsory treatment in the forensic and civil mental health systems of British Columbia: Arts & Social Sciences: School of Criminology; 2010.